Forest Pines Care Limited

Chelmsford Nursing Home

Inspection report

East Hanningfield Road
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Chelmsford
Essex
CM2 7TP

Tel: 01245478189

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Chelmsford Nursing Home provides accommodation, personal and nursing care for up to 64 people, some of whom were living with dementia. There are external and internal communal areas for people and their visitors to use and the service is split over two floors. Nursing care, including palliative care is carried out on the first floor and people living with dementia reside on the ground floor of the home.

This unannounced focused inspection was undertaken on 22nd March 2016. There were 59 people receiving care at the time of inspection.

The provider had received their first ratings inspection at this location in December 2015 and the service was found to be good in all key areas. However, since the previous inspection we had received intelligence that care practices had become unsafe. The registered manager had been dismissed and the service no longer had a registered manager in position.

There had been a number of changes at the service since their last inspection. The provider had also recently changed. We found that staff morale was low and that staff felt they did not have the right amount of safe and skilled staff to care for people in an individualised way. The service relied heavily on the use of agency staff who were often deployed to manage highly complex people's needs, often isolated away from regular staff. There had been some safeguarding incidents regarding agency staff and people at the service, however, managers had not assured themselves that agency staff had the appropriate skills.

The service had not learnt from incidents of falls, challenging behaviour and recent safeguarding, and reactively managed risk rather than identifying and managing common themes. There was a lack of strong leadership at the service and the deputy manager was covering the manager position as well as their own. However, on the day of our inspection a new manager had started at the service and had made the appropriate notification's to register with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

The management team failed to monitor, assess, and take action to make any changes to improve the service based on feedback and incidents.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff did not identify themes of falls and challenging behaviour, and act to mitigate these risks appropriately.

Staff told us that there was not enough staff to deliver individualised and personalised care, evidenced by task orientated care delivery.

Staff did not receive regular supervisions and mandatory training was not up to date.

Communication systems between staff were poor.

The service had requested DOLS appropriately and, was compliant with their responsibilities under this legislation.

Staff reported safeguarding concerns appropriately.

Is the service well-led?

Requires Improvement

The service was not well led

Staff did not identify themes of falls and challenging behaviour, and act to mitigate these risks appropriately.

Staff told us that there was not enough staff to deliver individualised and personalised care, evidenced by task orientated care delivery.

Staff did not receive regular supervisions and mandatory training was not up to date.

Communication systems between staff were poor.

The service had requested DOLS appropriately and, was compliant with their responsibilities under this legislation.

Staff reported safeguarding concerns appropriately.

Chelmsford Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was a focused inspection to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Focused inspections evaluate the quality and safety of particular aspects of care. They take place when we are following up after a comprehensive inspection, or when we have received concerns and have decided to look into them without doing a comprehensive inspection of all aspects of the service. They only ask the relevant key question(s), rather than all of them.

This focused inspection took place on the 22 March 2016 and was unannounced. We carried out this inspection due to concerns that had been raised through our national customer support centre (NCSC). We inspected under the key questions of 'safe' and 'well-led'.

The inspection team consisted of two inspectors and one specialist advisor who specialises in nursing care.

Before the inspection, we reviewed all the information we held on the service. We spoke to local commissioners and the quality improvement team at Essex County Council.

During the inspection, we spoke to 10 people using the service, and six relatives. We interviewed 10 members of staff, including three qualified nurses and the deputy manager. We pathway tracked 14 peoples individual care, reviewed five bedroom daily documentation charts on the nursing unit and carried out care observations between staff and people at the service.

Requires Improvement

Is the service safe?

Our findings

All staff we spoke with were confident in describing what constitutes abuse and how to protect people from harm. All staff were trained in safeguarding adults from abuse, and said they would not tolerate any approach where they felt people were at risk of harm or abuse.

However, agency staff we spoke to did not have a good understanding of capacity and consent. Challenging behaviour of people had been reported, in particular when agency staff were providing care. We could not be assured that that agency staff were making appropriate decisions about a person's ability to consent to treatment. For example to get washed and dressed or take medication. This lack of knowledge may have contributed to episodes of challenging behaviour.

Staff did not follow procedures to ensure that people's risk from falls was managed appropriately. There was a heavy use of agency staff who were assigned to look after people who required 1:1 nursing care due to falls risk. Agency staff were assigned to care for people with the most complex needs. Agency staff told us that they did not always get the appropriate information from regular staff to manage the presenting risks, and they often felt isolated having to manage complex needs and behaviours.

We found evidence that a number of falls occurred when people should have been observed by staff, but the agency staff had not informed regular staff they had left the shift. This evidence was found in the acting managers investigations into a number of falls, however there was no clear action plan of how to mitigate this happening again. Agency staff continued to be assigned to observe people at high risk of falls. On the day of inspection another fall occurred when an agency member of staff had left the shift whilst on a one to one, and had not been replaced by a regular member of staff. Accidental falls and incident forms were detailed but limited in overall analysis, and there was not a consistent process in place to capture themes across a period of time.

We saw that staff were closely observing people at risk of falls, following them around with a clipboard to record what people were doing at regular intervals. Some people appeared to be agitated and distressed but staff on close observations did not engage with or attempt to distract people. We saw that staff interactions with people did not improve when people sat down, or when people were observed in bed. Consequently, people's agitation and distress was not always managed as well as it could have been. Staff did not appear to have the skills to talk to people who were distressed or agitated. We spoke to staff following people in this way and asked them what they were doing. One said, "Just following [person] in case they fall." When asked if they spoke to the person they replied, "Not really, they don't talk much." This meant that although the service had attempted to reduce the risk of people falling, they had not done so in a person centred way that could have contributed to a better quality of life for people.

The deputy manager told us that they had to trust that agencies would provide appropriate training to staff deployed to the service, however, they had not adequately assured themselves that agency staff had been appropriately trained, in particular in safeguarding vulnerable adults, mental capacity or management of actual potential aggression (MAPA). Regular staff received MAPA training to manage people who presented

with challenging behaviours could not be sure that agency staff would approach people with the same knowledge and skills.

Agency staff told us that they were often subjected to physical and verbal assaults from people requiring one to one support. One female agency staff member told us, "Sometimes I don't know what I will be walking into. It is sometimes scary. This person is supposed to only be assigned men." They told us that they would be required to watch people with challenging and complex behaviours for up to 12 hours a day with only a short break. If they needed assistance, they had to press the individuals call buzzer in the bedroom and wait for staff to answer it. However, some people told us they often waited a long time due to staff being busy, during which time they could be subject to violence from the person.

Agency staff did not read care plans and risk assessments so had very little understanding of the people they were caring for. We had received appropriately reported safeguarding concerns from the service, that a number of agency staff had been suspended, on different occasions, following verbal abuse towards people who had been challenging. We spoke to the new manager about the concerns of having irregular staff with poor knowledge of people with complex needs being assigned as the primary carer. We discussed the lack of staff support to provide compassionate, dignified, and safe care in such complex situations.

Risk assessments for people who had complex challenging needs were not robustly reviewed and monitored and staff did not explore triggers to challenging behaviours, or how they could alleviate a person's distress. This meant that people's observations were not reviewed regularly and changes were not being made to better support people dependant on their changing needs to ensure their safety.

Clinical governance meetings documented that staff must record when people received one to one time or the local commissioner's would withdraw funding. However, this meant that people receiving one to one time did not have plans in place to reduce the high level of observation. Consequently, we were not confident that people's one to one care had been appropriately reviewed that might demonstrate that the service was working towards people being cared for in a less restrictive manner. One member of staff told us that they felt people where sometimes aggressive because they felt restricted by a member of staff constantly with them.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Handover records did not communicate to staff taking over the next shift important aspects of people's care and changing needs. We saw that important information was not recorded in the handover sheets, such as if a person had experienced a fall, required additional medication for agitation or pain, or if they had presented with behaviour that challenged. Information provided was sparse, and that these were not individualised and person centred. Consequently, important information could be missed and people might not receive the care that was needed.

People's care records contained personalised assessments for identified risks for each person. On the nursing unit, these were written in enough detail to protect people from harm whilst promoting their independence. For example, we saw risk assessments on tissue viability using the Waterlow tool (The Waterlow tool gives an estimated risk for the development of a pressure sore in a given person. They also assessed mobility and potential for falls, personal care delivery, nutritional and fluid intake using the MUST tool (MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition), use of bed rails and capacity. Care records discussed the importance of independence and how this can be supported. Examples include enabling residents to go to any area on the first floor that they wished to at any

time (At least three different lounge areas). All people had full access to their bedrooms at any time.

Staff told us that there was not enough staff to deliver individualised and personalised care and this was evidenced by task orientated care delivery. Staff said there were enough staff on the rota but the proportion of agency staff was very high and there were shifts when the staffing numbers fell below the agreed safe level. People told us they sometimes waited for staff to attend to their needs. One person told us, "I would prefer to have a wash and get dressed earlier in the morning but often I receive care just before lunch which is not my preference."

Staff told us that the ability to provide care that people's met individual needs depended on how many staff were on shift and how well those staff knew people. Staff told us shifts were heavily covered by agency staff, who might not know people so well. One staff member said, "We have to operate in safe mode when we are short staffed and that is not always what our residents want, it's certainly not individualised. This also means our ability to spend time with our residents is limited and restricted."

Staff told us that on the occasions when regular staff were working and all staff attended work, staffing levels were safe and workable. However, there were many times when this was not the case. For example, staff told us it was usual to have only one or two regular staff on each shift with agency staff making up the numbers. We saw that this was reflected in the duty rotas. Staff also told us that, at times, it was not possible to source agency staff and the shift would be below the agreed numbers.

This was a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe. One person told us, "Yes I feel very safe here." Another told us, "It is extremely safe here, and we have staff around all day and night." One relative told us, "I have no concerns about safety at all, I feel very reassured on those aspects, that my relative is safe." One relative told us that they were very pleased with the care their loved one received, but that, "There are always a lot of agency staff at the weekend and they don't know [person] well, or what [person's] preferences are." Another said, "Staff always phone me when something happens."

We had received appropriately reported safeguarding concerns from the service, that a number of agency staff had been suspended, on different occasions, following verbal abuse towards people who had been challenging. We spoke to the new manager about the concerns of having irregular staff with poor knowledge of people with complex needs being assigned as the primary carer. We discussed the lack of staff support to provide compassionate, dignified, and safe care in such complex situations. The new manager had taken measures to address these concerns by the end of our inspection, by ensuring that only regular staff with knowledge of people would be assigned to provide one to one care. In addition, the manager told us that agency staff would work alongside regular staff so that they could be guided appropriately to needs of people at the service.

Medication storage, administration and disposal was in line with the service policy and procedures. Staff carried out a 10-point medication administration record sheet (MARS) checklist at the end of each shift. A signature sheet was in place so that staff could identify who had administered medications. People had medication profiles attached to the front of that MARS so that staff administrating medication could see how people liked to receive their medication. For example, if they liked medication given in their left hand or if they would like a certain drink with it. Body charts were in place to record where people received their pain patches. These were recorded correctly. Peoples pain was regularly assessed using the abbey pain scale (for measurement of pain in people with dementia who cannot otherwise verbalise) and pain relief was

reviewed and adapted accordingly with the GP.

Behaviour records were in place to monitor the effectiveness of PRN (as required medication). Medication plans were in place and when people had refused medications and required medications administered covertly, capacity assessments were undertaken with the appropriate people and best interest decisions were in place. Although, we found evidence that in one case reviewed, staff had repeatedly administered night sedation at inappropriate times in attempts to reduce a persons agitated behaviour. The doctor had reviewed this, but instructions given verbally to nurses that they could give night sedation early, had not been recorded. We reviewed medication records (MARS) and saw that the person received the night sedation at 19:00hrs every night over a couple of months. There was no documentation in handover sheets or in the person's notes to explain why it was given, or the effects of the medication on agitation. Staff told us they just routinely gave it to prevent agitation. We also saw that nursing staff woke the person at 22:00 hrs every night to give them their prescribed 22:00 hour medication, in spite of the person being sedated. The person had repeatedly fallen in the evening but staff had not considered the impact of the night sedation on mobility and consciousness as a cause of falls. Nurses had not taken responsibility to ensure that medication they administrated was safe to do so and consequently this had resulted in the person having an increasing number of falls. Following the investigation, the acting manager had developed an action plan that included qualified staff having to take advance medication training. We saw that staff had undertaken this training and their medication competency had been assessed accordingly. We saw that staff learned from this incident and that they had taken additional measures to record advice by GP's which required the GP to sign any clinically recommended treatment interventions.

All areas of the home were clean and tidy. Domestic staff attended to the cleanliness appropriate and the acting manager monitored this. People enjoyed the quiet areas to socialise. Toilets and bathrooms were clean. Wheelchairs and hoists were well maintained and people had their own slings when they required support with hoisting. Protective equipment such as gloves and aprons were available and the service had a good infection control measures in place to protect people from cross infection.

Requires Improvement

Is the service well-led?

Our findings

Staff we spoke to told us that morale was low and that they did not feel engaged with developments in the care home. For example, staff had not been told that a new manager was due to start working at the home during the week of our visit. Staff told us that they were not, "Surprised" about this as communication from head office was, "Generally poor." The last manager had been in post for 8 months. The service had been taken over by another provider and the deputy manager told us that this had been initially unsettling for staff.

We saw evidence that communication was inconsistent. For example, when staff could not attend key training events due to shift working patterns. They were unsure how to re-book themselves for the training. We could see no audit trail to show that these staff went on to attend the training. (This covered all training delivered in the previous six months and training planned over coming months). There was inconsistent evidence of staff training, in addition to those receiving supervision and appraisals.

All staff said they had reported their concerns about staff shortages and the high reliance on agency staff to the deputy manager and more senior managers within the provider group. Staff commented that there had been no improvements to this situation for several months and that as a direct result morale was worsening. Some people we spoke with and their relatives said that regular staff were put under, "Huge pressure" due to the over reliance on agency staff. Staff said that while some agency staff were familiar with peoples' needs the quality of the agency staff was, "Very variable." There was a heavy reliance on agency staff to cover shifts and care for people with the most complex needs. Managers had not assured themselves of the quality of training that agency staff received.

Managers told us that there was a high turnover rate due to the staff being offered more pay to work for agencies. This had made it hard to fill vacant posts or encourage people to stay. At the time of inspection, there were 10 health care assistant vacancies and two qualified nurse vacancies. Up to nine agency staff would work at the home during a 24-hour period. The service received funding to provide one to one care for people with complex needs who needed additional support to ensure theirs and others safety. However, the deputy manager utilised agency staff to provide the one to one care to people with complex needs. They had not linked a recent spate of safeguarding referrals following alleged abuse by agency staff on people at the service, with the use of agency staff providing one to one care to people with complex needs. However, they had taken immediate measures to remove people accused of abuse. We saw evidence that the deputy manager had implemented clinical governance meetings, which staff attended. It was identified that there was, "A lot of misconduct right now," yet managers had not explored the causes of the misconduct and had not learnt from the incidents.

Staff did not receive regular supervisions and care observations by senior staff to monitor care practices and assure themselves of the quality of care being offered to people. Qualified staff told us there was no time for care observation to take place. Some staff did not know when they had been last supervised. The deputy manager told us that if an issue was identified with someone's practice, for example in moving and handling people, they would be asked to have one to one supervision. We were shown an example of this, but it was

outdated and did not assure us that appropriate measures had taken place to ensure that staff had the training they needed to carry out safe care. The deputy manager had been trying to manage the home and their own duties with limited support.

Staff told us they felt able to report incidents, raise concerns, and make suggestions for improvements; however, they saw little evidence of these suggestions leading to any changes. They were not confident their more senior managers would listen to them from head office. For example, staff told us that, "There is far too much paperwork to complete and it is not individualised according to risk." Staff said they had raised this issue repeatedly but even more paperwork had been requested for completion. Another example given by staff was the inconsistent messages they were given on the role of the nursing staff. For example, staff said when the staffing numbers were too low some nurses would assist with personal care delivery and others would not. Staff were unsure what the expectations were with the deployment of staff and their expected roles and responsibilities. This lack of clarity was compounded by staff not receiving regular supervision where they may have been able to explore these issues.

The management team failed to monitor, assess, and take action to make any changes to improve the service based on feedback and incidents.

This was a breach of Regulation 17 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had requested Deprivation of Liberty Safeguarding (DoLS) appropriately and, was compliant with their responsibilities under this legislation. However, systems were not in place to monitor and track the DoLS applications. As a result, we did not find that there were any records of attempts by home to chase the authorisation once it had expired. There was not a comprehensive and robust system to review DoLS so the manager could not be assured that where people's needs might have changed. Whilst people's individual care needs had been reviewed regularly in the case notes we tracked, the service had not ensured that the information relating to any DoLS/MCA had fed into the care plans.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a heavy reliance on agency staff to cover shifts at the service. People, relatives and staff at the service told us that agency staff did not know people well. They did not read peoples individual care plans and risk assessments. They did not understand peoples individual needs and care provided was task orientated. Consequently care was not person centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was poor communication between staff at all levels and this meant that people's risks were not communicated effectively. The service did not have robust systems in place to identify themes and patterns to incidents. Management were reactive rather than proactively safeguarding people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The management team failed to monitor, assess, and take action to make any changes to improve the service based on feedback and incidents.